Harper Wyatt

This case involved a distinct type of child abuse called medical child abuse, formerly known as Munchausen's by Proxy. Medical child abuse occurs when a child receives unnecessary or even harmful care due to a primary caregiver's – usually a parent's – exaggeration or fabrication of symptoms, or even intentional creation of symptoms through physical harm. The accurate diagnosis of a medical child abuse case can take months, even years, for physicians to determine that a parent is intentionally making his or her child sick. These cases are especially difficult for medical providers because a parent can cause well-intentioned providers to prescribe medications and treatments that are unnecessary and not indicated by testing or clinical observation. In medical child abuse cases, a parent's exaggeration and fabrication frequently becomes greater over time, and the potential for escalation puts the child in greater danger.

Harper was born at 23 weeks and underwent an extended NICU stay for issues related to her prematurity. However, during Harper's time in the NICU, she improved and was eventually able to breathe on her own and taken off oxygen.

On Aug. 28, 2017, Harper, now 23 months old, presented to Texas Children's Hospital West Campus during Hurricane Harvey. While at Texas Children's, Harper underwent extensive observation and treatment to address symptoms described by her mother that indicated diabetes insipidus, sleep apnea, seizures, feeding difficulty, and insufficient oxygen. None of these symptoms were verified through in-hospital observations or clinical testing. A therapeutic 10-day separation from her mother was recommended. Once Harper began her therapeutic separation as an inpatient at Texas Children's, she improved at a rapid rate as she was weaned from unnecessary medications and treatments.

We consulted with a nationally renowned expert on medical child abuse, Dr. Marc D. Feldman. Dr. Feldman served as the Clinical Professor of Psychiatry and Adjunct Professor of Psychology at the University of Alabama (UA), Tuscaloosa, Alabama. A Distinguished Fellow of the American Psychiatric Association, he is the author of more than 100 peer-reviewed articles in the professional literature. Dr. Feldman is an

international expert in factitious disorder, Munchausen syndrome, Munchausen by proxy, and malingering.

Dr. Feldman concluded Harper was indeed a victim of medical child abuse; that Harper's mother repeatedly resisted scaling back treatments, and Harper was in danger of imminent harm in her mother's care. He also advised that until Harper's mother acknowledges her role, reunification is not advisable and may place Harper again in imminent danger.

"Based on the facts known to Texas Children's and its practitioners, I believe firmly that the decision to report Ms. Ajshay James to CPS in 2017 was mandatory under the circumstances. Failure to have done so would have breached the standard of care. The CPS report of suspected maltreatment of Harper Wyatt was made under Texas's mandatory abuse reporting law (V.T.C.A., Family Code 261.101), which establishes a legal duty requiring physicians and other specified individuals to make a report when they have cause to believe that a child has been subjected to abuse and/or neglect.

I have found no evidence that Texas Children's or its staff acted with malice or negligence. Instead, they fully complied with the responsibilities of mandatory reporters of suspected child abuse. A so-called "separation test" (i.e., separation of the daughter, Harper Wyatt, from her mother) was also required as a diagnostic maneuver—one that ultimately reinforced the necessity of the report. The separation from Ms. James was clearly in Harper's best interests."

In this case, the suspicions were driven by a number of warning signs: that reported symptoms or behaviors were not consistent with observations; that extensive medical assessments did not identify a medical explanation for the child's reported problems; that the mother's observations were clear falsification of medical signs and symptoms; that the concerns were raised by multiple practitioners; that the presumptive diagnoses were in most cases driven solely by Ms. James's reports; and that symptoms resolved when the child was separated and well-protected from the influence and control of the alleged abuser. Medical child abuse cases are sometimes initially ambiguous and unclear, but child protection must always be affirmed."

What is most gratifying to the providers in this case is that once Harper was separated from her mother, she thrived. Today she is healthy, developing and without any of the interventions or medications the doctors prescribed to address her mother's repeated claims of symptoms. Now, under her father and paternal grandparents' continual care, Harper continues to improve and is, in all respects – other than a slight speech delay, a normal healthy child.

Updated Responses to Hixenbaugh's Questions from 9-4-19

Diabetes insipidus:

This is what Dr. Donaruma testified on 9/15/17:

THE WITNESS: She also has had a concern for diabetes insipidus. Again, mother was giving reports that this child -- diabetes insipidus has nothing to do with sugar, it has to do with urine output and sodium regulation. So mother was saying she pees so much that she's drinking, you know, a liter and a half a day and I can't keep up with 20 diapers a day and that's clearly abnormal and so the endocrine doctor was impressed by the quality of the history and so he began medication. It turns out off the medication she doesn't pee 20 diapers a day, she's just fine. She doesn't have that problem.

This gives the impression that Ms. James sought out this treatment and that the doctor's diagnosis was based only on the history she provided. But according to a note in Harper's medical records from February 2017, it was a Texas Children's neurologist who made the initial referral to the endocrinologist after an MRI showed a potential problem with Harper's pituitary gland. The endocrinologist cited the MRI, along with the diaper count, in his decision to prescribe medication, writing, "*Her imaging findings as well as her clinical picture ... are consistent with central diabetes insipidus.*" (Of note here: It is not reflected in the medical record, but Ms. James says one of her home health nurses attended this appointment with her and helped calculate the diaper count, since changing diapers was part of their duties. This would have been a question to ask Dr. Jeha, but I understand he was not consulted.)

1. **Diabetes Response:**

Dr. Donaruma's testimony is accurate. The medical reality is that Harper does not have diabetes insipidus (DI), and she has *never* had DI. By nature of the condition, when a child truly has DI, the resulting symptoms are persistent. Despite various interactions with TCH practitioners for 11 months prior to Harper's initial appointment with Dr. Jeha, Ms. James never reported that Harper had problems with excessive voiding. These symptoms were never observed or objectively verified during any hospital admission, and since being taken off her DI medication (DDAVP), Harper has had no problems.

The MRI findings that prompted Harper's referral to endocrinology were non-specific. Ms. James' first-time complaints of 20 plus significantly-soaked diapers, frequent wetting of her clothes and bed, and excessive thirst caused Dr. Jeha to give a provisional diagnosis of DI, which otherwise would not have been given. Moreover, when subsequent urine labs confirmed that Harper did not suffer from DI, Ms. James then alleged that she gave Harper the DDAVP *before* getting the labs performed (in direct violation of Dr. Jeha's instruction) to ensure the diagnosis remained. The reason for Harper's DI diagnosis was the exaggerated history provided by Ms. James, a situation that often occurs in medical child abuse cases, where a parent or other caregiver deliberately misleads an attending physician in order to seek treatments for their child that are unnecessary.

Dr. Jeha has made clear that he would never have prescribed medications and treated Harper for DI, but for the excessive history given by Ms. James. In light of the medical facts, Dr. Donaruma's testimony was completely reasonable. Additionally, your statements about Dr. Donaruma's testimony are incomplete, and so the meaning of her complete testimony is altered. During the October 12, 2017 hearing, which you do not cite, Dr. Donaruma specifically testified about the significance of the MRI.

Cranial orthotic:

This is what Dr. Donaruma testified on 9/15/17:

Q. And as far as the medical devices, specifically the helmet, were you aware that the child had a helmet that she wore at one point?
A. I actually saw her that day on the elevator but didn't know, yeah, it was Harper.
Q. Okay. And did you find anything in her medical records that would have made that something she required?
A. No.
Q. Okay, so it's your medical opinion that she didn't need the helmet?
A. Yes, it's my opinion.
Q. Where did she get the helmet?
A. She got the helmet because she asked for it.

This commentary is not supported by the medical records that Dr. Donaruma said she relied on. The records show that several Texas Children's doctors (Maria Rossell 4/26/16, William Whitley 5/13/16, Alyssa Bahorich 5/15/16) diagnosed Harper, upon physical examination, with plagiocephaly, a condition commonly known as flat head syndrome, which is more common in children born prematurely. Later, on 6/13/16, a neurosurgeon, Dr. Thomas Luerssen, digitally scanned Harper's head and, based on the results, recommended that she wear a cranial orthotic to correct the problem. A nurse practitioner in the hospital's cranial deformities clinic recommended Harper wear the device for 23 hours a day. Ms. James complied with those instructions and stopped putting Harper in the device when doctors told her it was no longer needed.

2. Cranial Orthotic Response:

The helmet played no role in Dr. Donaruma's medical child abuse analysis or CPS referral, which she made clear at the September 15, 2017 hearing. She was asked questions about the helmet by the attorneys when testifying and gave her opinion based upon her review of the records. Her opinion was reasonable. Further, while Harper utilized the helmet on a temporary basis to address her plagiocephaly, she certainly did not require a helmet at the time Dr. Donaruma testified, and she does not require a helmet now.

Your analysis of Dr. Donaruma's testimony appears incomplete, which changes the full meaning of her words. During the October 12, 2017 hearing, which you do not cite, Dr. Donaruma specifically referenced Harper's plagiocephaly and that the helmet was prescribed. Again, Dr. Donaruma did not consider the issue of Harper's helmet in her determination of medical child abuse.

Seizures:

This is what Dr. Donaruma testified on 9/15/17:

A. She has not had seizures ever observed outside or inside a medical institution but the reports from mother are driving the history or are driving the treatment because doctors use parental history to determine an appropriate treatment plan. So her seizures had never been verified.

And this is what she testified on 10/12/17:

A. She's never had seizures observed by any medical professional.

But medical records show that, following a reported seizure in July 2016, one of the nurses who cared for Harper at home told doctors she "witnessed this episode as well and attests to mom's description." The home nurse said that she "noticed some twitching movements of all extremities," according to a note by another Texas Children's doctor. The nurse also "noticed desats into the 40's," the note said, indicating that she was suffering a serious breathing episode. (Of note: Some of the home nurses who cared for Harper 24 hours a day said they were never contacted by Dr. Donaruma or any other Texas Children's doctors to ask whether they also observed the symptoms Ms. James had been describing.)

3. Seizures Response:

No seizures were ever observed in a hospital or clinical setting, despite reports from Ms. James that seizures were occurring frequently. Through her therapeutic separation, Harper received inpatient care at TCH on 67 days and had over 30 outpatient visits, all without demonstrating any seizures or seizure-like activity. Various EEG's, including a 48-hour continuous EEG, were normal with no seizures, and an MRI of Harper's brain revealed no seizure pathology. Harper was started on seizure medication (Keppra) based solely on Ms. James's persistent reporting of seizures and seizure-like activity, which again could never be clinically verified despite continuous observation and objective testing. Similar to Harper's other purported conditions and treatments, the therapeutic separation confirmed that she did not have seizures, and she does not have seizures today.

The medical evidence overwhelmingly demonstrates that Harper was not experiencing seizures. Dr. Donaruma performed a comprehensive review of Harper's medical records and relied on the specialized practitioners at TCH, including its team of skilled pediatric neurologists, to reach her conclusions regarding seizures. The observations on one or two occasions of a home health nurse, which may have been based on presumptions caused by Ms. James, may or may not be consistent with seizures, and would have provided little clinical evidence. Dr. Feldman addressed this inquiry in his comments, which were shared with us and with you earlier:

> "[H]ighly specialized pediatric experts had observed this child repeatedly in a hospital setting, and that this fact should carry great weight. Home health nurses do not have the same specialized training as pediatric physicians, and their reports should be put in the context of the entire medical record. The fact that the home health nurses purportedly attested to Ms. James's description on an occasion or two does not compete with the consistently normal observations and testing in the hospital. The overwhelming evidence from the thousands of pages demonstrates that Ms. James constantly provided information

that was almost never replicated in a hospital or other clinical setting. It is vital to compare the information provided by the suspected perpetrator with the objective observations of the providers while the child is undergoing diagnostic and therapeutic separation."

Sleep apnea:

This is what Dr. Donaruma testified on 9/15/17:

THE WITNESS: She was born early so she absolutely had pulmonary problems. As you grow you get more lung strength and those needs diminished. She was represented as having what's called obstructive sleep apnea. So you think of it commonly as snoring, but it's when children they stop breathing because they have a blockage in their airway. She doesn't have that. Her pulmonologist did test. She didn't really need the BiPap she was on.

But the medical records show that a Texas Children's pulmonologist diagnosed Harper with moderate obstructive sleep apnea in May 2016 and another doctor ordered nighttime breathing support based on the results of an in-hospital sleep study. Further, even the updated sleep study in September 2017 diagnosed Harper with mild obstructive sleep apnea, so it's not true that she didn't have that condition entirely at the time of this testimony. (One other point here, on the breathing issues: Records reveal nine instances in which Texas Children's therapists reported steep drops in Harper's blood-oxygen levels, prompting them on a few occasions to increase her oxygen support during physical therapy sessions, but those reports were never mentioned in court.)

4. Sleep Apnea Response:

Dr. Donaruma's findings were largely based on Harper's condition in September of 2017. Medical child abuse cases sometimes involve children born prematurely who may have numerous developmental issues due to early delivery, about which a parent, usually the mother, may be extremely anxious. The difference in medical child abuse cases occurs when, as the child improves and becomes less dependent upon treatments and therapies, the mother, rather than being pleased with her child's progress, tries to continue the status quo and keep the child in a compromised state. In that regard, Ms. James would appear to fall precisely into this pattern.

Harper's September 3, 2017 sleep study, which Dr. Donaruma testified about at the hearing, was in the normal range. She did not require oxygen or BiPAP, she did not experience desaturations, her pCO2 values were normal, and no ENT consultation was required. It is important to look at the child's clinical presentation and trend over time. Here, Harper did not have any significant apnea or blockages in her airway, she clearly outgrew any pulmonary problems related to prematurity, and BiPAP and oxygen were not necessary. This was again confirmed during Harper's therapeutic separation. While Harper's sleep study from 2016 did note moderate obstructive sleep apnea (while maintaining adequate oxygen saturations and without significant elevation of pCO2), the physicians' orders for breathing support were heavily based upon Ms. James's excessive reporting.

Ms. James constantly provided information regarding apneic events that could not be replicated clincially. Ms. James repeatedly reported that Harper was having apneic events that would frequently cause her to become cyanotic, ashen, and/or unresponsive and often require stimulation, resuscitation, and even CPR. These purported apneic events could not be confirmed in a clinical setting despite extensive observation and workup over 19 months. Further, Harper's home apnea monitor logs over 110 days fail to corroborate Ms. James's constant reports of apneic episodes and demonstrate Harper had no significant issues.

Your reference to oxygen saturations from nine physical therapy sessions uses a few records out of context when the overwhelming body of medical evidence demonstrates the contrary. When children receive PT,

they often move about and cry, which typically result in inaccurate readings and increasing oxygen out of an abundance of caution.

Working with mom:

Dr. Greeley told me that the first step in these cases is to try to work with the mother: "So, overwhelmingly the first step is, 'Mom, what's going on? How can we help?' And we as pediatricians, our default position is we trust, and believe, and want to be with Mom as the primary caretaker, Dads also. ... When we see kids that we have some concerns, what we would expect to do is to sit down with Mom and say, 'Mom, this is what's going on. It seems like maybe we should cut back these two medicines because I think that's contributing. What do you think about that?' And work with Mom, and maybe even bring in a therapist for Mom, because how Mom responds to that can be helpful. 'Why don't you want to pull that back? Why don't you want to change it? Why don't you want to take the feeding tube out? What is your concern?' And that would be how we would handle it."

That does not appear to be what happened in this case. During Harper's September 2017 hospitalization following Hurricane Harvey, doctors proposed weaning Harper from BiPap and daytime oxygen. Ms. James acknowledges that she initially resisted, because there hadn't been any follow-up sleep studies and these weren't Harper's normal doctors, but ultimately she agreed to remove daytime oxygen, and after the new sleep study, agreed to remove the BiPap. A Texas Children's doctor noted Ms. James' reaction to the positive sleep study result in Harper's medical record: "After telling mother results of sleep study she stated, 'We prayed for this ... Very happy to hear the good news.'"

If the doctors had concerns about the other treatments, why didn't they suggest weaning them before contacting CPS? In court, Dr. Graff explained the reasoning: "Because, in cases of medical abuse or fabricated illness, it is really contraindicated to bring this up to the perpetrator."

But how can you know someone is a perpetrator before you've suggested weaning any other medical treatments?

5. **Working with mom Response:**

Dr. Feldman's prior comments, included below, address the physicians' efforts to work with Ms. James over many months prior to the August 28, 2017 admission, which Ms. James resisted. Ms. James also resisted efforts to scale Harper's treatments back during her August 28, 2017 admission, including weaning oxygen and BiPAP, and she expressed frustration with the medical staff for wanting to perform the sleep study. Dr. Feldman's comments also addressed the concern about reunification and confronting a mother suspected of medical child abuse and the potential for the perpetrator to escalate the situation to prove the child was in fact sick. Further, while it can be appropriate for a pediatrician to work with the mother about over reporting and potential fabrication to deescalate the situation, as the practitioners did here, once suspicions of medical child abuse are confirmed, the child abuse pediatricians will not confront the suspected perpetrator. That is standard medical practice in these cases.

> "Harper's physicians first put Munchausen's by proxy (now more descriptively termed "medical child abuse") into their differential on March 23 2016—531 days before Drs. Graf and Donaruma reported suspected medical child abuse to DFPS. Obviously, then, the judgment about MCA was gradual, not rushed. Harper's providers gave Ms. James the benefit of the doubt for an extended period while they worked to observe the reported episodes and identify the cause, with no success despite great effort. Prior to the separation and over the course of many months, a number of doctors at TCH had frequent interactions with Ms. James and worked to obtain an accurate history and encouraged Ms. James to

report Harper's symptoms and conditions appropriately and accurately. In addition to inpatient recommendations, Dr. Louis and the professionals at the TCH Complex Care Clinic attempted to deescalate the medical care and treatments being given to Harper (e.g., oxygen saturation monitoring, oxygen administration, BiPAP, Tylenol/ibuprofen) and encourage accurate reporting of the child's condition. They offered counseling, obtained thorough histories, and questioned inconsistencies and suspected exaggerations of Harper's condition.

Specifically, on March 3, 2017, Dr. Louis recommended that Harper discontinue continuous pulse oximetry monitoring. Dr. Louis wrote that she was concerned that Ms. James continued to insist that Harper be connected to pulse oximeter and oxygen that impedes her movement. Five days later, Dr. Louis again stated that she wanted Harper off pulse oximetry during therapies. On June 23, 2017, Dr. Louis notes that during the last two visits, Harper was no longer prescribed supplemental oxygen, and discontinuation was uneventful. However, she reports that Ms. James still insists that Harper needs 3 liters of oxygen. Three weeks later, Dr. Louis once again encourages Ms. James to wean the oxygen. Dr. Louis again noted concerns about the accuracy of Ms. James' reporting, and was dissuaded from making therapeutic decisions based on the Ms. James reporting alone. At this visit, Dr. Louis noted that she spent a total of 60 minutes with the family, with greater than 50 percent of the time engaged in counseling, coordinating care, and discussing these concerns.

To continue, when Harper would receive therapeutic treatment for her alleged conditions, such as Keppra for purported seizures and DDAVP for purported excessive voiding, Ms. James continued to report excessive seizure activity and voiding, causing the frequency and dosing of Harper's medication to increase. Ms. James appeared unwilling to reduce Harper's medications and treatments, and worked to increase them by continuing to exaggerate Harper's condition and symptoms."